POLICY AND COMMUNICATIONS BULLETIN
THE CLINICAL CENTER

Medical Administrative Series

M93-8 (rev.) 4 October 2000

MANUAL TRANSMITTAL SHEET

SUBJECT: Use of Particulate Respirators
(PRs, N-95s, or Powered Air Purifying Respirators [PAPRs])
to Reduce Airborne Transmission of
Infectious Organisms in the Clinical Center

1. Explanation of Material Transmitted: This issuance provides guidance to healthcare personnel regarding protection against airborne transmission of infectious organisms. The policy was reviewed by the Medical Executive Committee on 3 October 2000 and approved with minor changes.

2. Material Superseded: MAS No. M93-8 (rev.), dated 1 July 1997

3. Filing Instructions: "Other" Section

   Remove: No. M93-8 (rev.), dated 1 July 1997

   Insert: No. M93-8 (rev.), dated 4 October 2000

DISTRIBUTION

Physicians, Dentists and Other Practitioners Participating in Patient Care

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PURPOSE

To establish a uniform policy for the use of particulate respirators (PRs) for the care of patients with suspected or documented active pulmonary or laryngeal tuberculosis, and to establish a requirement for departmental policies when PRs are routinely used to prevent airborne transmission of organisms for specified procedures in the Clinical Center.

POLICY

Patients who are suspected or proven to have infectious tuberculosis will be placed on Respiratory Isolation Level III by the staff in consultation with the Hospital Epidemiology Service. Healthcare workers who enter the patient's room or who have close contact with the patient (e.g., Messenger and Escort personnel) will wear PRs for these contacts.

CONSIDERATIONS AND RELATED ISSUES

PRs may be used not only for Respiratory Isolation Level III, but also as part of an area-specific infection control strategy attempting to prevent airborne transmission of organisms in high risk areas or during high risk procedures (e.g., as a routine prevention strategy in the bronchoscopy suite). CC departments and

services using PRs in this manner will develop procedures detailing their use in each of these settings; if assistance in developing these procedures is needed, the Hospital Epidemiology Service (HES) is prepared to provide support. Procedures will be initially reviewed and approved by the Hospital Infections Committee; approved procedures will be placed in the CC Hospital Infection Control Manual. Procedures will be reviewed by the Hospital Infections Committee at least biannually to assure currency.

For the CC policy to be in accord with Federal guidelines for the use of PRs, staff must be educated about the risks for airborne/ droplet transmission of tuberculosis, trained in the use of PRs, and medically cleared to use them. The Hospital Epidemiology Service and the CC Environmental Safety Officer are charged with the responsibility to train CC staff about the risk of transmission of pulmonary tuberculosis and measures to prevent transmission. PR training will consist of fit-testing and instructions in the use of these devices. The CC Environmental Safety Officer will maintain the fit testing procedures, manufacturer's information and a current list of all individuals enrolled in the CC's Disposable Particulate Respirator Protection Program. The HES will maintain a current list of all individuals enrolled in the Powered Air Purifying Respirator (PAPR) Program. Supervisors will be sent a list of enrollees on a regular basis. Supervisors should monitor these lists and notify the Safety Office when new employees need to be fit tested. Medical clearance determinations for individual health care workers to use PRs will be made by the Occupational Medical Service (OMS), Division of Safety. Medical evaluations will be performed by OMS as appropriate.

Reducing tuberculosis risks for visitors is extraordinarily difficult. Training visitors in the use of PRs is impractical, record keeping and documentation requirements for training are quite labor-intensive, and identification of visitors who may be at substantially increased risk for serious sequelae of tuberculosis (e.g., parents of HIV-infected children who may be themselves HIV-infected) is both technically and legally problematic. Thus, for several reasons, visitors' access to patients with suspected or documented pulmonary tuberculosis should be restricted as much as possible. Instances in which visitors are essential to the care of patients should be managed case-by-case, in consultation with the HES.

PROCEDURES

1. Patients with transmissible tuberculosis infections (e.g., suspected or actual pulmonary tuberculosis) will be identified and placed on Respiratory Isolation Level III by the staff in consultation with the HES.

2. Such patients will have a sign placed on their doors and the front of their charts indicating the need for staff members to use PRs in the room. Staff members should use PRs while providing care for these patients as outlined in the education/training sessions.

3. Non-staff visitors (e.g., family members and volunteers) should be restricted from such patients' rooms until the efficacy of anti-tuberculosis therapy is evident. Essential visitors will be managed by the staff in consultation with the HES on a case-by-case basis; whenever possible and unless specific contraindications exist, immediate family members will be allowed to visit.

4. Since patients with infectious pulmonary tuberculosis usually have compromised respiratory function, such patients should ordinarily not wear PRs -- even when travel out of the room (e.g., for essential tests) is necessary. Patients should be taught to wear disposable surgical masks fitted as tightly as possible, and should not be left to wait in open hallways or waiting areas. Additionally, patients with actual or suspected pulmonary tuberculosis should never use a mask with an exhalation valve.